

## HMO SUMMARY OF BENEFITS

OFFICE VISIT COPAY: \$15. HOSPITAL ADMISSION COPAY: \$500.

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<b>INPATIENT CARE</b>	
<ul style="list-style-type: none"> <li>Semi-private room and board</li> </ul>	\$500 copay per admission
<ul style="list-style-type: none"> <li>Physicians' and surgeons' visits</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests</li> </ul>	Included in hospital copay
<ul style="list-style-type: none"> <li>Surgery</li> </ul>	Lesser of \$200 or 20%
<ul style="list-style-type: none"> <li>Anesthesia</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Maternity care:               <ul style="list-style-type: none"> <li>-Delivery of baby</li> <li>-Well-baby and nursery</li> </ul> </li> </ul>	\$500 copay per admission Lesser of \$200 or 20% Included in hospital copay
<ul style="list-style-type: none"> <li>Physical therapy and rehabilitation</li> </ul>	\$500 copay per admission; limited to first 90 visits per condition
<ul style="list-style-type: none"> <li>Radiation therapy and chemotherapy</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Mental health care, including psychologist's or psychiatric services<sup>1</sup></li> </ul>	\$500 copay per visit
<ul style="list-style-type: none"> <li>Alcohol and drug detoxification<sup>1</sup></li> </ul>	Included in hospital copay, up to 30 days per member per year.
<ul style="list-style-type: none"> <li>Private duty nursing</li> </ul>	\$15 copay per visit, \$5,000 annual maximum, \$10,000 lifetime maximum.
<b>OUTPATIENT MEDICAL CARE</b>	
<ul style="list-style-type: none"> <li>Office and specialist visits, preventive care, physical exams, eye exams, hearing evaluations, immunizations, allergy tests and treatment, nutrition counseling</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Primary and preventive care to age 19</li> </ul>	Covered in full
<ul style="list-style-type: none"> <li>Pap smear and mammography screening</li> </ul>	Included in office visit copay
<ul style="list-style-type: none"> <li>Prenatal care in physician office</li> </ul>	Covered in full
<ul style="list-style-type: none"> <li>Outpatient surgery</li> </ul>	Lesser of \$200 or 20%
<ul style="list-style-type: none"> <li>Outpatient Hospital or Ambulatory Surgery (facility copay)</li> </ul>	\$75 Copay
<ul style="list-style-type: none"> <li>X-rays, lab tests, MRI, CAT scans, other diagnostic tests.</li> </ul>	Included in office visit copay
<ul style="list-style-type: none"> <li>Second surgical opinion</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Second opinion by appropriate specialist for positive or negative diagnosis of cancer, recurrence of cancer, or recommended course of treatment</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Physical therapy: 90 visits per condition, per calendar year</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Mental health care<sup>2</sup></li> </ul>	30 visits plus 3 emergency visits per year. 10% coinsurance
<ul style="list-style-type: none"> <li>Alcohol and drug rehabilitation<sup>2</sup></li> </ul>	Not covered
<ul style="list-style-type: none"> <li>Routine foot care</li> </ul>	Not covered
<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	Not covered
<b>EMERGENCY AND URGENT CARE</b>	
<ul style="list-style-type: none"> <li>Emergency room care</li> </ul>	\$50 copay per visit, waived if admitted
<ul style="list-style-type: none"> <li>Care in a doctor's office</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Treatment in an urgent care facility</li> </ul>	\$15 copay per visit
<ul style="list-style-type: none"> <li>Ambulance service to hospital emergency room</li> </ul>	Covered in full

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SKILLED NURSING FACILITY <sup>3</sup>	Covered in full
HOME HEALTH CARE <sup>3</sup>	\$15 copay per visit; up to 200 visits per calendar year
HOSPICE CARE	\$15 copay per visit up to 210 days
PRESCRIPTION DRUGS <sup>4</sup>	After a deductible of \$100 per individual or \$300 per family; per 34 day supply, \$5 copay for generic, \$10 copay for brand name when prescribed by a HIP participating physician and filled at a participating pharmacy.
DURABLE MEDICAL EQUIPMENT	Covered in full.
DEPENDENT COVERAGE	Dependent children covered to age 19, end of month. Full-time students coverage to age 23, end of month. Duration of coverage may increase at group's option.

### FOOTNOTES

- 1** Inpatient and/or alcohol detoxification and Inpatient mental health services are limited to a combined total of 30 days per calendar year.
- 2** HIP Providers must be used for mental health care and alcohol services; HIP must be the referral source for the drug services.
- 3** Home Health care and skilled nursing facility benefits are provided in lieu of hospitalization. Inpatient physical therapy is limited to the first 30 days of each admission. There is no custodial care.
- 4** Drug formulary applies ;please see Pharmacy Directory for details.

You must use HIP Participating Providers for all services, except for emergency care. Any care not provided or referred by a HIP Participating Provider will not be covered. HIP Participating Physicians and Provider have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP.

This summary is provided for information only; it does not contain complete details of the Plan, which are available only in the Contract, and it does not constitute an Agreement.

HIP Health Plan of New York (HIP) is an EmblemHealth company.